Developmental & Assistive Therapy Service Documentation Log

Student Information

Name: _____ **Date of Birth (Mo/Day/Year):** _____

Diagnostic Code: _____

Provider Information

Provider Name: _____ **Provider Title:** _____

Supervisory Union: _____ **Name of School:** _____

IEP Service:

List the activity being provided as it appears on the IEP.

IEP Activity	Individual or Group	Minutes Per Session	Sessions Per Week	Hours Per Week

Developmental & Assistive Therapy service listed above was provided to this student as shown in the calendar below:

Service Dates: The numbered boxes below reflect the days of the month. Enter month and year for the month(s) of billing period. Mark an "X" for each day that the Developmental and Assistive Therapy service was provided for the minutes and group size listed above. **If the minutes per session or group size are different then what is listed above, the actual minutes per session or group size should be indicated on the calendar**. For services provided in groups, only include those provided in Medicaid billable group size. For professionals, the group size must be six or less students and for paraprofessionals, the group size must be four or less students.
DO NOT USE PENCIL OR WHITE OUT.

Month _____ Year _____ Month _____ Year _____

Use this set of dates for a two-month billing period

1	**2**	**3**	**4**	**5**	**6**	**7**		**1**	**2**	**3**	**4**	**5**	**6**	**7**
8	**9**	**10**	**11**	**12**	**13**	**14**		**8**	**9**	**10**	**11**	**12**	**13**	**14**
15	**16**	**17**	**18**	**19**	**20**	**21**		**15**	**16**	**17**	**18**	**19**	**20**	**21**
22	**23**	**24**	**25**	**26**	**27**	**28**		**22**	**23**	**24**	**25**	**26**	**27**	**28**
29	**30**	**31**						**29**	**30**	**31**				

Indicate the total number of hours of billable service provided during the billing period:	**1:1 Service**	**Hours**
	Small Group	**Hours**

Provider Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

Supervisor Name (Printed): _____